STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 84840-001**
v

Humana Insurance Company
Respondent
_____/

Issued and entered
This 17th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 2, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The matter was accepted on November 2, 2007. Humana Insurance Company was notified of the external review and was requested to submit the information used in making its adverse determination. Humana provided the information and documents on November 7, 2007.

The issue here can be decided by applying the terms of the certificate of coverage, the contract defining the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner has health care coverage under a group policy. He had prostate surgery at XXXXX in XXXXX and was hospitalized from October 27 to October 29, 2006. XXXXX is not a network provider. Claims were submitted to Humana which paid the claims at the non-network benefit level leaving the Petitioner responsible for charges totaling $27,753.29. The Petitioner appealed. Humana reviewed the claims but affirmed its decision. A final adverse determination was sent to the Petitioner October 19, 2007.

III
ISSUE

Is Humana required to pay more for the Petitioner's care at XXXXX from October 27 to October 29, 2006?

IV
ANALYSIS

Petitioner's Argument

In planning for his surgery, the Petitioner contacted Humana to determine what his personal out-of-pocket expense would be if he stayed in-network or decided to go out-of-network. He says he was told he had approximately $1,300.00 remaining of the $3,000.00 non-network calendar year cost sharing and $500.00 for in-network. He further says he was told these amounts would be his maximum out-of-pocket costs.

The Petitioner says he decided to have his surgery at XXXXX because the difference between network and non-network costs was only $800.00. He states that before his surgery he discussed his insurance coverage with his urologist and XXXXX who contacted Humana and reaffirmed that his remaining calendar year "cost sharing" would be $1,300.00.

The Petitioner states the company did not offer information about or explain that the covered charges would be reduced to maximum allowable fees and the non-network provider is not

obligated to accept the reduced payment.

The Petitioner believes that since he was told by every source available to him that his maximum cost would be $1,300.00 that is all he is obligated to pay. He believes Humana should provide coverage for XXXXX at the network level of benefits.

Humana Insurance Company's Argument

Coverage is based on the network status of a provider. Services from non-network providers require a $1,000.00 per person calendar year deductible. Eligible expenses are then paid at 60% of covered charges until an out-of-pocket of $3,000.00 is met. The Petitioner is responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance and/or copayment.

In the glossary of the Petitioner's policy, maximum allowable fee for a covered expense is defined as:

> The lesser of:
>
> - The fee charged by the provider for the services;
> - The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services;
> - The fee established by us by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by us;
> - The fee based upon rates negotiated by us or other payors with one or more network providers in a geographic area determined by us for the same or similar services;
> - The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
> - The fee based on a percentage determined by us of the fee Medicare allows for the same or similar services provided in the same geographic area.
>
> **Note:** The bill you receive for services from non-network providers may be significantly higher than the maximum allowable fee. In addition to deductibles, co-payments and coinsurance, you are responsible for the difference between the maximum allowable fee and the amount the provider bills you for the services. Any amount you pay to the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Humana asserts that eligible charges in excess of the maximum allowable fee are the member's responsibility. They argue the charges were considered according to the policy provisions and the processing of the Petitioner's claims was correct.

Commissioner's Review

The Commissioner has considered the arguments and documentation of both parties as well as the certificate of coverage. The Commissioner understands the Petitioner's unhappiness that he has incurred higher out-of-pocket costs than anticipated. However, in this external review the Commissioner is bound by the terms and conditions of the Petitioner's certificate of coverage. The Petitioner's policy, on page 5, includes the following provision:

> UNDERSTANDING YOUR COVERAGE
>
> If you receive services from a non-network provider, we will pay benefits at a lower percentage and you will pay a larger share of the costs. Since non-network providers have not agreed to accept discounted or negotiated fees, they may bill you for charges in excess of the maximum allowable fee. You are responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance and/or co-payment. Any amount you pay to the provider in excess of your coinsurance or copayment will not apply to your out-of-pocket limit or deductible.

While the Petitioner's plan covers non-network provider services, they are subject to a higher deductible and coinsurance. Non-network providers do not have contracts with Humana. The plan provides benefits for covered charges to the non-network provider to the extent that the service or treatment doesn't exceed Humana's maximum allowable fee for that service. In addition to any required deductible and/or coinsurance, the non-network provider may bill for the difference between the provider's charge and Humana's maximum allowable fee. Therefore, the insured can expect to have higher out-of-pocket expenses when receiving non-network services.

It is regrettable that a conflict exists concerning how the coverage was presented to the Petitioner. However, the Commissioner is not allowed to make findings of fact about disputes based on oral statements that may have been made since, in the absence of a full hearing, the Commissioner cannot reasonably determine what was said in such conversations.

The Commissioner finds that Humana paid the Petitioner's claims according to the terms and conditions of coverage.

V
ORDER

The Commissioner upholds Humana's adverse determination of October 19, 2007. Humana is not required to pay more for the Petitioner's services from October 27 to October 29, 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.